Rape Prevention Education Program

Evaluation Task 1: Capacity Assessment

Prepared for:
Alaska Department of Health and Social Services
Division of Public Health

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Introduction

Purpose

Traditionally, the focus of SV data collection and management in Alaska has been on demonstrating the need to fund services—primarily victim services—and on design and delivery of effective services, again primarily for victims and their families but also to prevent recidivism among perpetrators. As the name suggests, the Rape Prevention Education Program (RPE) emphasizes prevention.

In March 2017, McDowell Group conducted Task One of the RPE Program Evaluation. The purpose of Task One is to conduct a capacity assessment that documents Alaska's current situation with respect to collecting, tracking and using statewide sexual violence (SV) prevention data and to identify potential improvements to support future development of prevention indicators that will assist in evaluating the program’s effectiveness. This report describes the initial findings of Task One.

Two main types of SV data are relevant to the capacity assessment of data systems and data utilization:

1. Outcome/impact data, which primarily includes information about victimization, law enforcement, and criminal justice.
2. Prevention data, which includes information about individual, family, community, and societal factors and conditions that contribute to and protect against SV.

Methods

Information about and opinions of the capacity assessment were gathered primarily through key informant interviews. The RPE Program staff identified an initial group of key stakeholders. Additional stakeholders were identified during stakeholder interviews. Eighteen individuals provided input during 11 interview sessions. In one case, an staff member compiled responses from co-workers during a formal meeting where they addressed key questions, then shared the results with McDowell Group. Stakeholders represented a wide array of arenas working in SV prevention, including:

- Chronic Disease Prevention and Health Promotion
- State Injury Prevention
- Tribal Injury Prevention
- Non-Profit Injury Prevention
- School Health and Wellness
- Sexual Violence Prevention Programs
- Sexual Violence and Sexual Assault Advocacy and Policy
- Maternal and Child Health
- Statewide Health Quality and Improvement
- Rape Prevention Education Program Staff
- Behavioral Health Policy
All interviews were conducted by phone. Prior to the interview, stakeholders received a copy of the CDC Rape Prevention Education Capacity Assessment Tool. The intended methodology was to use questions within the CDC tool during each interview; however, in practice, depending on the stakeholder’s role and experience, most were unable to answer the questions directly. The process was therefore changed to a more open-ended interview with the interviewer covering the five core areas identified in the tool more generally:

1. Data systems to monitor SV indicators
2. Staff and consultants
3. Partnerships
4. Data Access and Integration
5. Leadership

Definitions

This report employs the following terms:

**Outcome/Impact Data:** Information about victimization, law enforcement, and criminal justice. Generally, it is event data or associated data after a sexual incidence occurs. It includes outcome indicators such as the rape and assault rates, crime rates, and shelter utilization rates.

**Prevention Data:** Information about the wide range of social factors and conditions that influence, but predate an incident of SV. Examples include bullying, social-emotional wellness skills, community connectedness, social connectedness, and unemployment rates.

**Sexual Violence (SV):** Used throughout the report as a comprehensive term that includes rape, sexual assault, or any type of violence with a sexual aspect.
Current Alaska SV Programs

This section provides a summary of current SV Prevention Programs within Alaska.

**Relevant Programs and Initiatives**

**RPE Program**

RPE Program works with SV coalitions, education institutions, rape crisis centers, community organizations, and other entities to strengthen SV prevention systems throughout Alaska. It aims to prevent SV perpetration and victimization before it begins. The RPE Program funds *Bringing in the Bystander*, an evidence-based intervention at the University of Alaska Anchorage (UAA). It also funds *Lead On*, a youth leadership program focused on developing healthy relationship skills and healthy sexuality skills. It also supports the Alaska Prevention Summit, a bi-annual conference providing community level staff with SV prevention skills, competencies, and system support.

**Alaska Network on Domestic Violence and Sexual Assault**

In 1976, a women’s grassroots effort established the Alaska Women’s Resource Center in Anchorage and, two years later, Alaska’s first statewide conference on domestic violence. The state’s first shelter for battered women was established in Anchorage in 1977. By 1978, there were service providers of various types, primarily volunteers, in at least nine Alaska communities and the Alaska Network on Domestic Violence and Sexual Assault was incorporated using primarily federal funds. In 1980, federal funding expired and the State of Alaska became the primary funder for 16 domestic violence programs.

**Council on Domestic Violence and Sexual Assault (CDVSA)**

In 1980, when it authorized $1.8 million for domestic violence programming, the Alaska Legislature also required an entity within state government to oversee funding allocations. In that year, AS 18.66 established the Council on Domestic Violence and Sexual Assault (CDVSA) within the Alaska Department of Public Safety.

**Alaska Safe Children’s Act**

During the 2015 Legislature, versions of Bree’s Law and Erin’s Law were combined into the Alaska Safe Children’s Act (HB 44). Bree’s Law—named after Breeanna Moore, a 20-year old Anchorage resident who was killed by her abusive boyfriend—mandates dating violence education in Alaska’s public middle and high schools. Erin’s Law—named after Erin Merryn, an advocate for sexual abuse victims, who was sexually abused herself as a young child—mandates sexual-assault prevention education in Kindergarten through 12th grade.

The Alaska Safe Children’s Act was expanded beyond dating violence and sexual-assault prevention education in Alaska’s public schools to include provisions for training of school district personnel to recognize and report child abuse, neglect, and sexual abuse of a minor, as well as suicide awareness and prevention training for teachers, administrators, counselors, and specialists who work with students in grades 7 through 12.
The Act also created a 10-member Safe Children’s Act Task Force that provided recommendations to the Alaska Department of Education and Early Development (DEED) on June 30, 2016 of model curricula for use by school districts, including:

- Suicide prevention training (for school staff), such as Connect Suicide, Youth Mental Health First Aid, Alaska Gatekeeper, Safe TALK, and others.
- Sexual abuse and sexual assault awareness training and prevention (for school staff and students K-12), such as Fourth R Healthy Relationships, Speak Up Be Safe, Safer Smarter Kids, The Great Body Shop, and others.
- Dating violence and abuse awareness training and prevention (school staff and students grades 7-12), such as Safe DATES, Second Step, The Great Body Shop, Fourth R Healthy Relationships, and others.
- Alcohol and drug-related disabilities training for school staff
- Alcohol and drug abuse education (for students K-12), such as Lifeskills Training, Lions Quest Grades, Positive Action, Project Toward No Drug Abuse, Too Good for Drugs, and others.

The Task Force made other recommendations, including:

- Posting toll-free numbers in schools to report child abuse or neglect.
- Development of an eLearning module for teacher training on trauma and ACES, resiliency and communication planning.
- Sustainable funding for supporting Alaska Safe Children’s Act.
- Coordination with agencies within the community that provide domestic violence and sexual assault victim services.

**Other Users of SV Data**

The organizations and initiatives listed in the previous section focus explicitly on SV and sexual assault. They need and use SV data for program planning and evaluation. However, SV data is relevant to virtually all social systems that deal with physical, emotional, or intellectual health and safety, including:

- Children and family services providers
- Law enforcement
- Tribal health and tribal justice systems
- School systems
- University systems
- Healthcare providers
- A wide variety of community groups

Many State of Alaska departments are particularly dependent on SV data, including:

- Department of Law
- Department of Education and Early Development
- Department of Health and Social Services
- Department of Corrections
- Department of Public Safety
Current Alaska SV Data Systems

This section provides a summary of current SV Data Systems in Alaska.

Primary Sources for SV Indicators

Alaska Dashboard

The Alaska Dashboard provides an overview of population indicators related to domestic violence and sexual assault in Alaska. Alaska’s CDVSA maintains and uses the Dashboard to monitor trends, strengthen policies and prevention practices, and make changes to programs. 2015 marks the fourth year of dashboard publication. In addition to display of key Alaska indicators, the Dashboard also provides national comparisons where available and analyzes trends for all indicators. An image of the 2015 Dashboard is available in Appendix 1.

Healthy Alaskans 2020

Healthy Alaskans 2020 (HA2020) is a collective impact effort to improve health and ensure health equity for all Alaskans by coordinating partners from diverse sectors around the state. Led jointly by the Alaska Department of Health and Social Services (DHSS) and the Alaska Native Tribal Health Consortium, HA2020 has identified 25 health priorities (or indicators) to address the goal to reduce the number of Alaskan’s experiencing domestic violence and sexual assaults and other goal areas, including:

- Reduce Alaskan deaths from cancer
- Increase the proportion of Alaskans who are tobacco-free
- Reduce the proportion of Alaskans who are overweight or obese
- Increase the proportion of Alaskans who are physically active
- Reduce Alaskan deaths from suicide
- Reduce the number of Alaskans experiencing poor mental health
- Increase the proportion of Alaska youth with family and/or social support
- Reduce the number of Alaskans experiencing alcohol and other drug dependence or abuse
- Reduce Alaskan deaths from unintentional injury
- Increase the proportion of Alaskans who are protected from vaccine-preventable infectious diseases
- Reduce the proportion of Alaskans experiencing infection disease
- Increase the proportion of Alaskans with access to in-home water and wastewater services
- Increase the proportion of Alaskans protected against dental diseases
- Reduce the proportion of Alaskans without access to high quality and affordable healthcare
- Increase the economic and educational status of Alaskans

Within the goal area of reducing the number of Alaskans experiencing domestic violence and sexual assault, HA202 selected three indicators, described in the following table.
Table 1. HA2020 Indicators: Reduce the Number of Alaskans Experiencing Domestic Violence and Sexual Assault

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (2010)</th>
<th>HA 2020 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of unique substantiated child maltreatment victims per 1,000 children</td>
<td>15.3 per 1,000</td>
<td>14.4 per 1,000</td>
</tr>
<tr>
<td>Rate of rape per 100,000 population</td>
<td>75.0 per 100,000</td>
<td>67.5 per 100,000</td>
</tr>
<tr>
<td>Percentage of adolescents who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months</td>
<td>9.1%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Following selection of indicators, the next stage of the collective impact process is identification of evidenced-based strategies and related implementation plans to address all 25 indicators. Each strategy has an associated measure. To begin this process, the HA2020 Advisory Team selected four goal areas for pilot implementation activities: suicide, socioeconomic status, tobacco use, and domestic violence.

The strategies identified for domestic violence indicators as part of the pilot initiative are summarized in the following table.

Table 2. HA2020 Strategies to Address Domestic Violence Indicators

<table>
<thead>
<tr>
<th>Goal: Reduce the number of Alaskans experiencing domestic violence and sexual assault.</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator: Reduce rate of child maltreatment</strong></td>
<td></td>
</tr>
<tr>
<td>Strategy 1: Promote screening and monitoring for child abuse in primary care offices and public health clinics.</td>
<td># of medical offices routinely screening for child abuse in primary care offices throughout Alaska</td>
</tr>
<tr>
<td>Strategy 2: Expand home visiting programs.</td>
<td>TBD</td>
</tr>
<tr>
<td>Strategy 3: Expand and strengthen quality of early childhood programs.</td>
<td>TBD</td>
</tr>
<tr>
<td>Strategy 4: Train providers on brain development, adverse childhood experiences (ACEs), and resilience.</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Indicator: Reduce rate of rape</strong></td>
<td></td>
</tr>
<tr>
<td>Strategy 1: Strengthen the abilities and skills of communities to prevent violence.</td>
<td># of community prevention teams coordinating primary prevention efforts through planning, coordination and evaluation across the Social Ecological Model (SEM)</td>
</tr>
<tr>
<td>Strategy 2: Promote values and beliefs that reinforce safe and healthy relationships.</td>
<td># of adult women reporting past year/lifetime incidents in Alaska</td>
</tr>
<tr>
<td></td>
<td># adult Alaskan’s reporting lifetime incidents of domestic violence/SV</td>
</tr>
<tr>
<td></td>
<td># adult Alaskan’s reporting violent incidents within the past five years</td>
</tr>
<tr>
<td>Strategy 3: Develop plans and approaches for early interventions with juveniles who commit acts of sexual abuse or act out in sexually inappropriate ways.</td>
<td># of regional and/or statewide discussions being hosted on this topic</td>
</tr>
<tr>
<td></td>
<td># of regional and/or statewide needs assessments conducted on this topic</td>
</tr>
<tr>
<td></td>
<td># of trained professionals with specific skills and training in this arena</td>
</tr>
<tr>
<td></td>
<td># of regional, state and national partnerships developed</td>
</tr>
</tbody>
</table>
Goal: Reduce the number of Alaskans experiencing domestic violence and sexual assault.

Measure

Indicator: Reduce the percentage of adolescents who were ever physically hurt on purpose by their boyfriend or girlfriend

<table>
<thead>
<tr>
<th>Strategy 1: Strengthen the abilities and skills of communities to prevent violence.</th>
<th># of community prevention teams coordinating primary prevention efforts through planning, coordination and evaluation across the Social Ecological Model (SEM)</th>
</tr>
</thead>
</table>
| Strategy 2: Promote values and beliefs that reinforce safe and healthy relationships. | # of adolescents reporting past year/lifetime incidents  
# of Schools in compliance with Alaska Safe Children’s Act, SA prevention curriculum grades K-12  
# of school districts implementing Social Emotional Learning (SEL) programming with fidelity through Association of Alaska School Boards (AASB) multi-year grant opportunity. |
| Strategy 3: Implement evidence-based school violence prevention programs. | # of schools implementing health promotion programs among teens  
# of schools in Alaska in compliance with Alaska Safe Children’s Act curriculum requirements |

Informed Alaskans (IA) Initiative

*Informed Alaskans* (IA) is a data visualization initiative to provide individuals, health organizations, health providers, and policy makers with easy access to state, regional, and community health data. All data are available to users in both graphical and text formats. IA stands for its two comprising elements: IBIS and Atlas.

**INDICATOR-BASED INFORMATION SYSTEM FOR PUBLIC HEALTH (IBIS)**

IBIS, released in December 2013, is an online public health resource site that provides statistical data and contextual information on the health of Alaskans and the state of Alaskan’s health care system. Data are available in several forms on IBIS, including: publications, health indicator profiles, and dataset queries. Publications describe frequently requested public health topics in detail and are available on individual section pages. Indicator profiles provide data on specific public health issues in Alaska and present numerical data, its public health context, status of the indicator, and an overview of how the indicator is being addressed. Currently, IBIS has 88 indicator profiles, ranging from incidence of lung cancer to fluoridated drinking water and teen birth rate. Users can also custom query one of five available datasets: (1) Behavioral Risk Factor Surveillance System (BRFSS), (2) Childhood Understanding Behaviors Survey (CUBS), (3) Pregnancy Risk Assessment Monitoring System (PRAMS), (4) Youth Risk Behavior Survey – local (YRBS), and (5) YRBS – statewide.

**INSTANTATLAS**

Released in June of 2012, InstantAtlas interactive maps provide spatial and temporal depictions of health indicators. Each page displays a time series chart, map, bar chart, and time series animation of an indicator. Additionally, users can view a data table, review the indicator survey question, and compare a selected indicator to statewide or regional averages. The Atlas displays information from three datasets: (1) BRFSS, (2) Student Weight Status Surveillance System, and (3) YRBS.
Major Databases Containing SV Data

Alaska has multiple sources of SV and SV risk-factor data, but currently lacks a single data collection or access point for SV indicators. The Domestic Violence Dashboard comes closest to fulfilling this function but falls short, particularly in the areas of prevention and policy data. The table below shows the major databases that contain Alaska SV data, which ones include secondary or tertiary prevention indicators in addition to primary prevention indicators, and the entity that owns/controls the data.

<table>
<thead>
<tr>
<th>Database</th>
<th>Primary Prevention Indicators</th>
<th>Event/Occurrence (Secondary/Tertiary Prevention) Indicators</th>
<th>Data Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Birth Defects Registry</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Alaska School Health Profiles</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Alaska Vital Statistics – Birth Certificate</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Education Statistics &amp; Reports</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Economic and Labor Datasets</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Help Me Grow</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Home Visiting Data</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Knowledge, Attitudes, and Beliefs Survey</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>School Climate and Connectedness Survey</td>
<td>√</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Alaska Medicaid Data</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Behavioral Risk Factor Surveillance System</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Campus Climate Survey</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Childhood Understanding Behaviors Survey</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>National Survey of Children with Special Health Care Needs</td>
<td>√</td>
<td>√</td>
<td>Federal</td>
</tr>
<tr>
<td>National Survey of Children’s Health</td>
<td>√</td>
<td>√</td>
<td>Federal</td>
</tr>
<tr>
<td>Pregnancy Risk Assessment Monitoring System</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Youth Risk Behavior Survey</td>
<td>√</td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Adult Protective Services</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Automated Information Management System</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Alaska Crisis Line</td>
<td></td>
<td>√</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Alaska’s Children Alliance</td>
<td></td>
<td>√</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Alaska Department of Law</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Department of Corrections</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Health Facilities Reporting System</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska State Troopers – Law Enforcement</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Trauma Registry</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Victimization Survey</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Alaska Vital Statistics – Death Certificate</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Council on Domestic Violence and Sexual Assault Utilization</td>
<td>√</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>Emergency Response System Data</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
<tr>
<td>Maternal and Child Death review</td>
<td></td>
<td>√</td>
<td>State</td>
</tr>
</tbody>
</table>
Database (cont’d) | Primary Prevention Indicators | Event/Occurrence (Secondary/Tertiary Prevention) Indicators | Data Owner
--- | --- | --- | ---
National Child Abuse and Neglect Data System | ✓ | | State
Office of Children’s Services | ✓ | | State
Surveillance of Child Abuse and Neglect | ✓ | | State
Uniformed Crime Reporting System | ✓ | | Federal
Violent Death Reporting System | ✓ | | State

State government agencies/entities own most of the potential prevention data sources, but the owners sit across multiple departments, divisions/agencies, and sections. The following table summarizes the location of potential prevention data sources (checked in the previous table) across state government agencies. While support and willingness exists to share data throughout state government, no written data sharing agreements, such as Memorandums of Agreement or Understanding (MOA/MOU) exist with the explicit purposes of sharing SV prevention and systematic data reporting. With the exception of one, these data sources rely on data reported at an individual level. The Alaska School Health Profiles is the only source that systematically captures policies.

**Table 4. Potential Sexual Violence Data Sources by Primary Prevention Indicators, Event/Occurrence Indicators, and Data Owner**

<table>
<thead>
<tr>
<th>Database</th>
<th>Department</th>
<th>Division</th>
<th>Section/Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Birth Defects Registry</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>Help Me Grow</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>Home Visiting Data</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>Childhood Understanding Behaviors Survey</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>National Survey of Children with Special Health Care Needs*</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>National Survey of Children’s Health*</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>Pregnancy Risk Assessment Monitoring System</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Women’s, Children’s, &amp; Family Health</td>
</tr>
<tr>
<td>Behavioral Risk Factor Surveillance System</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Chronic Disease Prevention &amp; Health Promotion</td>
</tr>
<tr>
<td>Youth Risk Behavior Survey</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Chronic Disease Prevention &amp; Health Promotion</td>
</tr>
<tr>
<td>Alaska School Health Profiles</td>
<td>DHSS</td>
<td>Public Health</td>
<td>Chronic Disease Prevention &amp; Health Promotion</td>
</tr>
<tr>
<td>Alaska Medicaid Data</td>
<td>DHSS</td>
<td>Public Assistance</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Education Statistics &amp; Reports</td>
<td>DEED</td>
<td>Statistics &amp; Reports</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Economic and Labor Datasets</td>
<td>DOLWD</td>
<td>Research &amp; Analysis</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Campus Climate Survey</td>
<td>UAA</td>
<td>College of Health</td>
<td>Justice Center</td>
</tr>
<tr>
<td>Knowledge, Attitudes, and Beliefs Survey</td>
<td>UAA</td>
<td>College of Health</td>
<td>Justice Center</td>
</tr>
</tbody>
</table>

*The previous table lists these as federal sources because they are federally administered, compiled and analyzed. They remained in this table because the Department of Health & Social Services has a dataset of the results.
**Additional Data Collection Initiatives**

Two data collection initiatives active in the past have no plans to continue as funding is no longer available. These are the *Alaska Victimization Survey* and the *Knowledge, Attitudes, and Beliefs Survey*.

**Alaska Victimization Survey**

The UAA Justice Center manages the Alaska Victimization Survey with the CDVSA. The survey provides a statewide and regional data on SV and assault behaviors through a phone-based survey. The data guides planning and policy development as well as serves as an evaluation measure for prevention and intervention programs. The survey uses the core questions of the *Centers for Disease Control and Prevention National Intimate Partner and Sexual Violence Survey* to survey women. The Justice Center completed the survey in 2010 and 2015 with additional regionally surveys scattered between the years based upon available funding. Future surveying plans and funding do not exist.

**Knowledge, Attitudes, and Beliefs Survey**

CDVSA partnered with the UAA Justice Center to develop and field a *Knowledge, Attitudes, and Beliefs (KAB) Survey*. The statewide survey established estimates of the knowledge, attitudes, beliefs about sexual assault and domestic violence among Alaska adults. During this initial capacity assessment, efforts to determine the status of the survey were unsuccessful.
SV System Strengths, Challenges, and Data Gaps

This section provides a summary of SV data strengths, gaps, and challenges.

SV System Strengths and Challenges

Awareness of SV

Alaska as a state has a relatively high degree of awareness, both socially and politically, of issues associated with sexual and domestic violence. Its network of domestic violence shelters is well established, and their importance is widely recognized. For a variety of reasons, state agencies also tend to be sensitive to the impacts of SV and domestic violence. The CDVSA and Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) have played important roles in this awareness, as have State efforts such as the domestic violence initiative launched by the previous administration (Governor Sean Parnell from July 2009 through most of 2014), the experience in rural Alaska of Village Public Safety Officers, tribal health providers, and tribal police, and a general recognition that Alaska faces high incidences of both types of violence.

Alaska has also begun to incorporate preventive/protective strategies into many of its SV and domestic violence efforts, for example in efforts to incorporate Developmental Assets into education by the Association of Alaska School Boards (AASB) and to respond to the broad implications of Adverse Childhood Experiences (ACEs) for public health across a broad spectrum of programs and disciplines. Further, Alaska makes extensive use of data sources such as the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System, and policy makers tend to be well aware of these tools.

For the most part, however, Alaska data systems are not designed or coordinated to make the most of this broader approach to sexual and domestic violence programs, and lack of access to potentially useful data is becoming a hindrance to effective program development. This section highlights key interview findings with respect to Alaska’s SV data capacity.

Implications of Alaska’s Economy

Alaska’s economy is in recession without a foreseeable recovery for several years, and this may influence the state’s capacity to gather and use SV data. The state budget system is in a crisis as our state budget relies on production taxes and royalties of Alaska’s oil industry. Further, sustained low commodity prices in the petroleum and mineral industries has resulted in dramatic shedding of jobs in the private sector. The Alaska Department of Labor and Workforce Development (DOLWD) issued the 2017 Employment Forecast; Alaska is expected to lose 7,500 jobs in 2017, following a loss of 6,800 jobs in 2016. These economic challenges are coupled with rural areas with small and isolated populations, lack of economic opportunities, limited capacity in some areas to address systemic health issues, limited and often high transportation costs, and residents’ modest level of educational attainment. These economic challenges must be recognized as a critical baseline of this capacity assessment as economic challenges contribute to underlying the capacity of state government to develop data systems for SV prevention.
Currently, it is not clear how Alaska’s economic struggles may impact SV programs. The main impact so far is to introduce considerable uncertainty. At the state level, the recession means state program budgets have been cut and likely will continue to be cut. State government employees have been asked to assume additional roles and responsibilities beyond their traditional ones without additional funding and to find efficiencies where there are fewer and fewer to be had.

Interviewees also expect significant cuts in federal funds, especially health and social services prevention funds based upon the national political climate. Combined, the state’s recession and national federal cuts creates a bleak economic situation. Consideration of these financial burdens must be recognized as part of the capacity and availability of funds to create new data infrastructure and relationships in state government.

Alaska Political Priorities

In addition to increasing budget pressure, Alaska has a new state governor (Governor Bill Walker) with somewhat different political priorities. In the recent past, SV prevention had political and financial support at the highest levels during Governor Sean Parnell’s administration from July 2009 through most of 2014 under an approach known as the “Choose Respect Campaign – Alaskans Ending the Epidemic of Domestic Violence and Sexual Assault.” During his administration, funding expanded, new policy on the issue evolved, regulations changed to support prevention, a sex-trafficking policy task force was established, and public advocacy and social norms were also affected. A senior advisor in the Governor’s Office focused solely on this effort and the leadership provided funding for additional staff in the CDVSA.

Other funding supported data-systems development to track the effectiveness of the work, in particular the fielding and analysis of the Alaska Victimization Survey and development of the Alaska Dashboard (both described earlier). This created a strong baseline of skilled staff, data systems, media campaigns, and community level coalition efforts. The Alaska Victimization Survey demonstrated the effectiveness of this comprehensive approach. It showed a decline in intimate partner and SV between 2010 and 2015. Beginning in December 2014, Governor Bill Walker’s administration has not maintained the emphasis on SV prevention. While much of the infrastructure and baseline data capacity built by the previous administration remains, there is no clear plan, funding source, political will, or policy effort to move forward at this time.

Historical Trauma Impacts

There are other systemic challenges evolving from Alaska’s historical trauma associated with sexual abuse in regional boarding schools and by clergy. Rural Alaska and the Alaska Native community were particularly hardest hit by these traumas. Social stigma, public awareness and acceptance, and generational responses (and impacts, such as ACEs) compound the impacts of this SV trauma.

Existing Data Systems Gaps

Alaska Dashboard Integration

The Alaska Dashboard serves as an excellent foundation for tracking SV indicators. However, it largely contains indicators related to domestic violence and sexual assault and includes just three prevention indicators. Other
limitations are that the Dashboard is statewide; it does not capture data regionally. The Dashboard also is not integrated within IBIS.

**Lack of Prevention Focus**

Interviews suggest that although SV practitioners recognize the importance of developing more data on prevention, there is not yet a consistent vision of what a prevention-based data system would look like. Interviewees noted it takes a long time to build prevention competencies among on-the-ground response staff.

There is not a systematic curriculum or orientation process that addresses prevention data for new SV workers. Neither are there ongoing, formal, staff-training programs about prevention in SV throughout the state that people can access any time. However, the Alaska Primary Prevention Summit is held every two years by the CDVSA. There are two tracks at the Summit, one for communities that have just begun building basic capacity on prevention of SV and the other for those that already have systems in place.

**Lack of Intentional Injury Focus**

Most tracking of injuries across the state has focused only on unintentional injuries. Interviewees ascribed this gap to a lack of high-level interest but also said tracing intentional injuries is challenging. It is hard to build intentional injury data systems without substantial coordinating support through policy, multiple agencies, staff skills, and standardized methods.

**TRIBAL INJURY PREVENTION PROGRAM**

The Tribal Health Injury Prevention Programs receives dedicated funds for injury prevention. The focus of this work is determined by Tribal Health Boards and directives from Indian Health Service. All the work under this program thus far has focused on unintentional injuries. Tribal Leaders have begun to prioritize suicide, but there is a gap in addressing SV as part of injury prevention efforts.

**Partnership Opportunities**

Many Alaska practitioners recognize that partnerships are critical to creating collaborative environments for sharing data. Following is a brief description of key partners and potential partners.

**Nonprofit Service Providers**

The trio of organizations—ANDVSA, CDVSA and the RPE Program—are recognized as a highly-dedicated network of domestic and SV victim services and a basis for strong partnerships. However, the “triumvirate” can also appear to those in other disciplines as insular and unwelcoming according to some interviewees. Some practitioners say this perception is a barrier to developing statewide prevention indicators.

**Tribal Providers**

The Tribal Health System and other tribal entities working in this area do not have well-defined links with others in the system. Interviewees indicate a gap exists in the capacity of the major SV agencies to integrate tribal health approaches. There has not been a formal relationship between the Alaska Tribal Injury Prevention
Program and the RPE Program because the former has not focused on intentional injuries to date as described above.

**State Health and Social Service Agencies**

The Chronic Disease Prevention & Health Promotion, and Women’s, Children’s and Family Health, and Education & Early Development have strong, but informal relationships. While all are described as responsive to data-sharing requests and a willingness to support each other’s work, they lack formal, written policies, procedures or statements of intent governing this area of cooperation. Similarly, there are no formal processes for engaging staff in the data management implications of new program planning and proposal writing.

Different agencies of state government collect and house data relevant to RPE but may not have the content expertise to recognize its value in an SV context. For example, Office of Children Services (OCS) collects and manages data about childhood experiences and events that could be important to RPE efforts and other public health prevention efforts. IBIS contains a query module system, but, at this time, it does not include OCS data.

**Law Enforcement**

With a few exceptions, for example the Alaska Violent Death Reporting System and the Surveillance of Child Abuse and Neglect, it is rare for law enforcement data to be shared and used by other agencies. However, law enforcement reports are useful in that they describe incidents in qualitative terms that are lacking in most public health datasets.

Interviewees suggested that a modest, but promising, step toward more collaboration might be to start with an agreement between the Alaska State Troopers, the RPE Program, and CDVSA. A first step would be a formal document that describes relationships and expectations around data for sexual assaults at an aggregate level that no other data system allows at this time, mirroring the strengths of the Alaska Violent Death Reporting System.

**School Health Policy and Curriculum**

Interviewees suggest there is a need for a school database of evidence-based health policies. Currently, when planning a prevention program or strategy in a region, there is no central location to see what school district policies exist, the health curriculum used, or the topics taught in the health curriculum. Implementation of the Safe Children’s Act is an opportunity to explore ways to document what school districts are doing around these issues. Currently, there is no data system to track implementation of the Act. Design of such a system could incorporate other types of useful information as well, for example the ability to link policy and curriculum changes with outcome trends.

**Key Positions and Personnel Issues**

Budget cuts have led to staffing reductions, as described earlier. This, combined with expected increases in retirements as baby boomers age, raise the specter of lost expertise and institutional memory. Budget cuts have taken a toll on ANDVSA, where two positions are currently open, and especially on CDVSA, which lost a third of
its staff, including the executive director position. Interviewees suggest, however, that loss of personnel is not yet a serious problem from a data management perspective.

**Information Based Indicator System**

Interviewees say IBIS is not currently threatened. It does not represent a large financial burden because software, servers, computers, etc. have already been purchased. DHSS remains committed to maintaining staffing levels, including a contract for technical assistance. The Chronic Disease Prevention and Health Promotion section recognizes the system saves time and resources by reducing data-request demands on staff.

Although the person leading IBIS development plans to retire, transition actions are already in place through multiple pathways. For example, DHSS has arranged for cross-training before key people retire. They received special permission to double-fill the position for up to a year to ensure transfer of knowledge. In addition, the Chronic Disease and Health Promotion section developed an internal Surveillance and Evaluation Team that meets monthly. These meetings are used to cross-train team members in Instant Atlas and IBIS. The person who supervise the now two data staff in charge of IBIS has also been intensely training on the functions, processes, and steps on concert with the two analysts so the management has a full understanding of the needs to manage and maintain the data resource.

**Planning Participation**

**Alaska Statewide Violence & Injury Prevention Planning Group**

Alaska is engaged in a collaborate strategic planning process to develop a state violence and injury plan that includes domestic violence as a priority. The planning group is developing a strategic injury prevention plan focused on unintentional and intentional injuries. While Alaska did not apply in the recent round of competitive applications, Lea leadership identified this as a priority and maintains staff and funding to continue moving the planning process forward. Alaska intends to apply for Core State Violence and Injury Prevention Program (SVIPP) funding in the future.

**Alaska Division of Public Health Strategic Plan 2010-2020**

The Alaska Division of Public Health Strategic Plan 2010-2020 focused on areas where there was a reasonable expectation of progress within relatively short time horizons. Although SV prevention falls under the plan’s high-level Goals and Values, the plan does not explicitly address SV in its key actions.
Data Opportunities

The key stakeholders interviewed for the capacity assessment made several suggestions for new or more effective SV data management. This section briefly describes some of those suggestions.

Potential New Data Components

Alaska School Health Profiles

The Alaska School Health Profiles survey captures a significant portion of sexual assault prevention data. However, this survey does not include alternative schools. This is a gap in coverage because YRBS survey results show substantial differences between traditional high schools and alternative high schools. Further, as described earlier, data do not exist on the policies and curriculums in schools that many high-risk students attend. Additional funding is needed to sample the alternative high school on these policies to capture a full picture of SV prevention policies.

The Alaska School Health Profiles survey allows additional questions to be added at the state level as long as they stay within the intent of the survey. This means it could potentially serve as tool to track changes from the Alaska Safe Children’s Act. However, CDC funding to analyze this potential is not available. Leaders would need to allocate additional funding for a team of people to collaborate on the questions and to analyze and report the results.

One other weakness of the School Health Profiles is that they do not allow for regional or school-by-school breakouts.

Sexual Orientation

Research has begun to demonstrate that Lesbian, Bisexual, Gay or Transgender (LBGT) status is an important sociodemographic variable to capture when developing appropriate prevention strategies and resources. However, many national and local datasets are not currently designed to accomplish this. The national BRFSS core questions required as part of the state participation include the LBG, but no Transgender. The YRBS core includes a LBGT question, but states are required to use a percentage of the core questions. Therefore, it is not necessarily required to ask the question.

Education

Strong relationships exist between Department of Education & Early Development and Division of Public Health. Interviewees pointed out there are no formal relationships between the Alaska Association of School Boards who own/manage the School Climate and Connectedness Survey and other public health programs. Closer formal, written relationships would facilitate more comprehensive data and data use.
Role of Leadership

Lack of energetic support at the highest levels of state leadership is beginning to blunt SV efforts that, in the past, have made significant progress. This change in priorities is symptomatic of shifting social norms, financial trends, and changes in policy focus. Alaska needs a clear plan to address the future of anti-SV efforts.
The section describes suggestions for improvement and recommendations for potential next steps toward building a foundational SV prevention data system at both the state and federal level. These recommendations are preliminary; finalized recommendations will be submitted by May 31, 2017.

**Suggested Areas for Improvement**

**State-Level Actions**

Bringing prevention and protective factors fully into Alaska’s SV data systems will require targeted strategies, several of which were suggested in the interviews and are summarized below.

**IDENTIFY SHARED PROTECTIVE FACTORS ACROSS MULTIPLE PREVENTION EFFORTS**

Staff tend to view the world from the perspective of their own programs whether they cluster around alcohol, substance use, injury, or violence prevention. Fragmented program funding, therefore, unintentionally drives divisions in primary prevention. With respect to shared risk and protective factors, people are doing similar work in disconnected and siloed ways. Research demonstrates that shared protective factors are often the same early indicators relevant to preventing alcohol use, illegal drug use, and injuries, and to boosting educational attainment. Pooling resources may be resisted because of “turf” considerations, but it has the potential to leverage some prevention strategies.

Regarding protective factors, one approach might be to develop a matrix identifying the shared risk and protective factors overlaid with types of prevention and communicate this information systematically to program managers. The approach should start small and then expand. It will be important to identify common shared protective factors within DHSS and develop a communication tool to distribute this matrix to all staff working on prevention.

The Alaska Statewide Violence & Injury Prevention Partnership has begun a similar document. It is intended as a living document to assist program managers. Consider supporting this and sharing it with non-traditional partners such as the Alaska Wellness Coalition. Many of the efforts are measuring the same protective factors associated with SV.

**CONSIDER DEVELOPING A PROTECTIVE-FACTOR DASHBOARD**

Once the matrix, above, has been completed and communicated to a broad audience of stakeholders, draw upon the identified protective factors as a potential source for a SV prevention dashboard that may serve additional audiences. Consider including SV system level indicators as additional measures. If a protective-factor dashboard is created, the coalition should be involved.
FIND WAYS TO INTEGRATE BETTER WITH THE EDUCATION SYSTEM FOR PREVENTION DATA

SEL skills, including resiliency skills and healthy coping mechanism skills, are critical protective factors for sexual assault. Not all school districts systematically employ SEL curriculum, practices, or approaches. Stress that these factors are valuable in the prevention of alcohol, substance use, injury, etc.

FIND WAYS TO STRENGTHEN THE CONTENT KNOWLEDGE BETWEEN WOMEN’S, CHILDREN’S AND FAMILY HEALTH, AND THE CHRONIC DISEASE SECTION

These two DHSS sections have a good relationship. Several interviewees indicated the Women’s, Children’s and Family Health (WCFH) is the right place for the RPE Program. The WCFM and Chronic Disease Prevention and Health Promotion section house many potential indicators and data sources for early prevention. However, not all data owners and/or program managers have the content knowledge to recognize their data and work may be related and support SV prevention. Find ways to share and communicate the content knowledge as well as involve data managers in program planning and grant development to help foster better understandings across the sections.

EMPHASIZE COMPREHENSIVE HEALTH EDUCATION

While recognizing that each school district has local control, emphasize the importance and long-term cost-savings of comprehensive health education. Invest in a research literature review to document the extent to which comprehensive health education has reduced long-term health outcomes. Look also at the cost of variation in the types of health education available in different parts of the state. Depending on where a person lives, they may graduate from high school without exposure to key topics.

ESTABLISH BETTER COORDINATION BETWEEN THE DIVISION OF BEHAVIORAL HEALTH AND THE DIVISION OF PUBLIC HEALTH

This is a natural partnership that could be improved. DHSS’s Division of Behavioral Health houses alcohol and substance use prevention. Some of the same core protective factors also prevent SV. Natural synergies between the Behavioral Health and Public Health divisions may exist. The Alaska Screening Tool could be useful to share and report community level indicators. In addition, consider exploring whether the Alaska Automated Information System (AKAIMS) may be a tool for population level SV indicators.

ENHANCE SUPPORT OF INTENTIONAL INJURIES INTO ALASKA’S INJURY PARADIGM

Traditionally, statewide and tribal health efforts directed and/or funding pushed resources towards preventing unintentional injuries. However, violence and intentional injuries have been identified recently as a priority in the Alaska through the Violence and Injury Prevention Strategic Planning process, and the state has allocated resources to focus on suicide as injury. This is a new shift in a positive direction to address unintentional injuries. However, gaps remain for addressing these complex issues. There is a need for more focused research and resources directed to these complex issues.

DEVELOP BETTER AWARENESS OF EFFORTS ACROSS VARIED HEALTH AND SOCIAL SYSTEMS

Alaska has three health systems including the Alaska Tribal Health System, the private system, and military (current and Veteran’s Affairs). In addition, many social service entities engage in these issues, but their work
crosses private, public, non-profit and tribal entities. Some interviewees described gaps in the ability of these systems to enter a “closed system” of domestic violence prevention (the big three: ADVSA, NDVSA, and RPE) focus largely within state government. Others said the tribal entities may not want to engage in this “network” (ADVSA, NDVSA and RPE) as it is a Western way of approaching the issue. There have been some efforts in the past to expand these relationships between, among, and within systems. They were not sustained, but resulted in new data reporting. Consider developing ways to create an awareness of SV prevention efforts across these systems.

**STANDARDIZE AND COMMUNICATE TERMINOLOGY**

**SV Terms**

Consider developing a standard list of terms used to reference work around SV. This would include definitions for SV, rape, sexual assault, consent, etc. This could potentially be a collaborative process with the ANDVSA, CDVSA, and UAA Justice Center so all organizations use the same definitions.

**Prevention Terms**

Develop a “policy” sheet that describes what is meant by prevention indicators for the initial onset of SV. Most interviewees assumed these would be event/incident indicators such as the rape and sexual assault rape, child abuse and neglect, or domestic violence events. Few interviewees referenced potential data sources and topics specific to prevention. A framing statement could help other programs and entities understand how the RPE Program defines and frames prevention as it may be different than how the public typically views prevention.

**PARTICIPATE IN THE ALASKA VIOLENCE & INJURY PREVENTION STRATEGIC PLANNING PROCESS**

For the first time, domestic violence and sexual assault is a priority for an Alaska injury prevention planning process. CDVSA plans to write the chapter focused on this area. As this process evolves, integrate statewide and community-level monitoring for SV prevention. Consider including the indicators identified as part of the RPE Evaluation Grants as this is considered a living and ongoing process.

**IMPROVE ACCESS TO THE EDUCATION DATA FOR TIMELY DECISION-MAKING**

A strong relationship exists between the education department and Public Health with respect to key public health surveys. However, consider additional ways to build data sharing bridges with SEL data collected in the *School Climate and Connectedness Survey*, education attainment, and other school system indicators.

**PARTICIPATE IN THE INDICATOR-BASED INFORMATION SYSTEM**

Review current indicators and find ways to integrate the Alaska Dashboard with IBIS. If a dashboard of prevention indicators evolves, include those in IBIS. If the Alaska Victimization Survey has another year of data, consider developing a query module on IBIS.
**Find Ways to Put an Economic Value to the SV Prevention System**

Interviewees mentioned a need to quantify the total dollar amount in Alaska focused on SV prevention compared to the amount for services and treatment. Some considered this among the most important data needed to establish additional prevention data systems. Another useful indicator would be the total cost to Alaska of SV or, at the minimum, the cost to state-funded entities. These dollar amounts may themselves serve as prevention indicators.

**Engage at a Pivotal Point in the Roll-out of Alaska’s Safe Children Act**

The Alaska Safe Children’s Act creates changes in curriculum across schools. The recommended curricula are evidence-based prevention strategies for SV prevention. School districts are mandated to roll this out by July 1, 2017. This is a pivotal time for both the law itself, and the associated tracking of data. Identify a way to fund a data system to track implementation of this law and a school health-policy database as described elsewhere in this report. Consider including fields to capture the curriculum used, topics covered, grades where implemented, and other key data.

**Develop a Workgroup for Prevention Indicators**

After standardizing SV prevention terminology and building consensus on definitions, begin a process to formulate a strategic plan for design and adoption of a SV prevention indicator reporting system. Identify what can be done with current funding and what will require new funding. Create an action plan with targets and dates for key milestones.

**Federal-Level Actions**

Interviewees said the following are key pieces of national-level support needed by local practitioners to encourage states in development of baseline infrastructure for SV prevention.

**CDC Continue to Invest In and Disseminate Cross-Cutting Prevention Research and Analysis**

In an applied setting, practitioners, program managers, and data analysts do not have time to invest in cross-cutting, evidence-based research. They rely on the CDC to create and support:

- Reports similar to *Connecting the Dots*
- In-depth literature reviews describing the evidence for these cross cutting protective factors
- Research on the scientific links between SEL skills and health/SV outcomes

Local practitioners use these tools to develop community level indicators for SV prevention.

**Invest in Sociodemographic Best Practices for Marginalized Communities to Assist in SV Prevention Efforts**

Identify best practices to allow vulnerable populations to self-report in data systems and survey instruments. In addition, provide communities with capacity building tools to collect, report, and address these vulnerable populations appropriately especially among youth. Important characteristics include disability status, gender identification, and homelessness associated with sex-trafficking.
The BRFSS and YRBS core modules are incomplete in their treatment of LBGTQ status. The CDC should add Transgender to the BRFSS. It would also be worthwhile for the CDC to invest in more education for local communities about how to talk about this topic at grassroots and policy levels, and to provide guidelines for including the topic in surveys.

YRBS requires a percentage of the core questions to be asked so the local YRBS teams can select questions from the core questions. This line of questioning about gender identification often falls out because of a lack of capacity to roll it out appropriately in communities. However, the CDC needs to support community and state-level capacity to talk, communicate, and engage youth stakeholders before adding Transgender questions.

**ADJUST RPE FUNDING**

Unlike most other federal base allocations, the RPE Program funding is based solely on population and does not account for cost of living or the geography costs of implementing in remote communities, most of which are not connected by roads. The RPE funding would be more effective in Alaska if it included additional, sustained funding to support geographically dispersed grantees with respect to implementation and evaluation. In addition, the RPE evaluation funding should be expanded as the core RPE grant regulations limit the use of the core funds for evaluation.

**INVEST IN STANDARDS AND DATA SYSTEMS FOR NON-FATAL INJURIES**

To develop a better understanding of how people die, the CDC invested in a complex data system (*Violent Death Reporting System*) to capture and describe fatality patterns. Alaska was one of the first states to participate in the *Violent Death Reporting System*. To tell a complete story of intentional non-fatal injuries, there needs to be a similar system for non-fatal incidences of intentional injuries that links data from multiple sources. WISQARS (Web-based Injury Statistics Query and Reporting System) provides data on non-fatal injuries, but lacks comprehensiveness. It should capture and/or provide best practices for integrating and standardizing the qualitative data from the first responder reports and the legal system as these data help paint a better picture of the incidents. This information is critical to understanding many of the complex system related intentional injuries.

Practitioners have only a partial understanding of how and why these non-fatal intentional injuries occur and the ways in which incidences overlap with behavioral health issues. This data system is critical to moving SV prevention strategies upstream.
## Appendix 1: Alaska Dashboard

### Key Issues Impacting Domestic Violence and Sexual Assault in Alaska

Reports of harm, utilization of services, and reports to law enforcement are much lower than actual incident rates. As the stigma of reporting violence lessens and as victim safety increases, those experiencing violence will be more likely to report and seek help, causing some of these indicators to increase over time. Estimates based on self-disclosures to survey questions may also be lower than actual victimization rates.

### Key Population Indicators for Alaska

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Starting AK Data</th>
<th>Current AK Data</th>
<th>Percent Change</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Exposure to Domestic Violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Percent of adults exposed to intimate partner violence of parent (BRFSS)</td>
<td>19.1%</td>
<td>22.1%</td>
<td>15.7%</td>
<td>-</td>
</tr>
<tr>
<td>2. Percent of mothers whose 3 year old child saw violence or physical abuse (CUBS)</td>
<td>4.0%</td>
<td>3.4%</td>
<td>-16.0%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Child and Youth Victimization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Percent of students experiencing physical dating violence in past year (YRBS)</td>
<td>9.1%</td>
<td>9.1%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Percent of students experiencing sexual violence in lifetime (YRBS)</td>
<td>10.1%</td>
<td>9.3%</td>
<td>-7.9%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reports of Harm (Child and Youth)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Rate of reported child abuse and neglect per 10,000 (US DHHS)</td>
<td>193.1</td>
<td>130.1</td>
<td>-32.6%</td>
<td>-</td>
</tr>
<tr>
<td>6. Rate of reported child sexual maltreatment per 10,000 (US DHHS)</td>
<td>5.6</td>
<td>6.5</td>
<td>16.1%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adult and Elder Victimization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Percent of women experiencing physical intimate partner violence in past year (AVI)</td>
<td>9.4%</td>
<td>N/A</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Percent of women experiencing sexual violence in past year (AVS)</td>
<td>4.3%</td>
<td>N/A</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9. Percent of pregnant women experiencing partner physical abuse (PRAMS)</td>
<td>3.6%</td>
<td>1.6%</td>
<td>-56.6%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reports of Harm (Adult and Elder)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Number of vulnerable adults reporting abuse or neglect (APS)</td>
<td>91</td>
<td>63</td>
<td>-30.8%</td>
<td>-</td>
</tr>
<tr>
<td>11. Number of vulnerable elders reporting abuse or neglect (APS)</td>
<td>111</td>
<td>77</td>
<td>-30.6%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Primary Prevention and Protective Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Percent of pregnant women whose health provider talked to them about DV (PRAMS)</td>
<td>60.0%</td>
<td>60.1%</td>
<td>0.2%</td>
<td>-</td>
</tr>
<tr>
<td>13. Percent of students comfortable seeking help from 3 or more adults (YRBS)</td>
<td>44.6%</td>
<td>42.8%</td>
<td>-4.0%</td>
<td>-</td>
</tr>
<tr>
<td>14. Percent of schools implementing Fourth R healthy relationship curriculum (DEED)</td>
<td>9.7%</td>
<td>24.0%</td>
<td>147.4%</td>
<td>-</td>
</tr>
<tr>
<td>15. Percent of students who feel connected to their school (SCGCS)</td>
<td>38%</td>
<td>39%</td>
<td>2.6%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Reports to Law Enforcement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Rate of rape reported to law enforcement per 10,000 (UCR)</td>
<td>N/A</td>
<td>12.5</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>17. Number of domestic violence related homicides reported to law enforcement (DPS)</td>
<td>5</td>
<td>11</td>
<td>120.0%</td>
<td>-</td>
</tr>
<tr>
<td>18. Number of elderly victims reporting DV-related sexual/physical assaults as AST (DPS)</td>
<td>79</td>
<td>122</td>
<td>54.4%</td>
<td>-</td>
</tr>
<tr>
<td>19. Number of sexual assaults reported to law enforcement (DPS)</td>
<td>804</td>
<td>813</td>
<td>1.1%</td>
<td>-</td>
</tr>
<tr>
<td>20. Number of sexual abuse of minors reported to law enforcement (DPS)</td>
<td>428</td>
<td>513</td>
<td>19.9%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Utilization of Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Rate of children evaluated by child advocacy centers per 10,000 (ACA)</td>
<td>81.9</td>
<td>90.8</td>
<td>10.9%</td>
<td>-</td>
</tr>
<tr>
<td>22. Rate of children utilizing domestic violence services per 10,000 (CDVSA)</td>
<td>81.6</td>
<td>77.5</td>
<td>-5.0%</td>
<td>-</td>
</tr>
<tr>
<td>23. Rate of children with domestic violence services per 10,000 (CDVSA)</td>
<td>72.8</td>
<td>52.0</td>
<td>-24.8%</td>
<td>-</td>
</tr>
<tr>
<td>24. Rate of adults utilizing services for sexual violence per 10,000 (CDVSA)</td>
<td>20.5</td>
<td>20.7</td>
<td>1.0%</td>
<td>-</td>
</tr>
<tr>
<td>25. Rate of youth utilizing services for domestic violence per 10,000 (CDVSA)</td>
<td>20.1</td>
<td>24.7</td>
<td>22.9%</td>
<td>-</td>
</tr>
<tr>
<td>26. Rate of youth utilizing services for sexual violence per 10,000 (CDVSA)</td>
<td>39.2</td>
<td>28.9</td>
<td>-26.3%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Offender Accountability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Percent of reported rapes resulting in an arrest (DPS)</td>
<td>N/A</td>
<td>40.8%</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>28. Rate of juveniles referred for sex offenses per 10,000 (DJJ)</td>
<td>10.9</td>
<td>11.8</td>
<td>8.3%</td>
<td>-</td>
</tr>
<tr>
<td>29. Rate of juveniles referred for a DV-related assault per 10,000 (DJJ)</td>
<td>38.5</td>
<td>36.1</td>
<td>-6.2%</td>
<td>-</td>
</tr>
<tr>
<td>30. Number of sexual assault cases accepted for prosecution (DOL)</td>
<td>111</td>
<td>135</td>
<td>21.6%</td>
<td>-</td>
</tr>
<tr>
<td>31. Percent of accepted sexual assault cases with a conviction (DOL)</td>
<td>63.0%</td>
<td>51.8%</td>
<td>-17.8%</td>
<td>-</td>
</tr>
<tr>
<td>32. Number of sexual abuse of minor cases accepted for prosecution (DOL)</td>
<td>109</td>
<td>118</td>
<td>8.3%</td>
<td>-</td>
</tr>
<tr>
<td>33. Percent of accepted sexual abuse of minor cases with a conviction (DOL)</td>
<td>64.4%</td>
<td>60.1%</td>
<td>-7.8%</td>
<td>-</td>
</tr>
<tr>
<td>34. Number of domestic violence cases accepted for prosecution (DOL)</td>
<td>2617</td>
<td>3270</td>
<td>25.0%</td>
<td>-</td>
</tr>
<tr>
<td>35. Percent of accepted domestic violence cases with a conviction (DOL)</td>
<td>73.8%</td>
<td>75.9%</td>
<td>2.8%</td>
<td>-</td>
</tr>
<tr>
<td>36. Percent of adult sex offenders who recidivate (DOC)</td>
<td>67.0</td>
<td>60.7%</td>
<td>-9.4%</td>
<td>-</td>
</tr>
</tbody>
</table>

### Progress:
- **Progress Satisfactory**
- **Progress Uncertain**
- **Progress Needs Improvement**

Percent change is relative to starting data. See definition on page 3. Percent changes may or may not be statistically significant.

Definitions for each population indicator and dates for current and starting data are found starting on page 4.
